

VSH Futures Advisory Committee
July 23, 2007 2:00 – 4:30 PM
Stanley Hall, Room 100, State Office Complex, Waterbury

Minutes

Present

Commissioner of Mental Health, Michael Hartman
Deputy Commissioner of Mental Health, Beth Tanzman

Advisory Committee Members: Kitty Gallagher, Adult State MH Program Standing Committee; Linda Corey, VPS; Ron Smith, DOC; Paul Dupre, WCMHS/VT Council; Nick Emlen, VT Council (for Jeff Rothenberg); Sally Parrish, advocate; Conor Casey, VSEA; Julie Tessler, VT Council Executive Committee; Ed Paquin, VP&A; Michael Sabourin, advocate; Anne Jerman, VSH; Xenia Williams, advocate; Meg O'Donnell, FAHC; Jill Olson, VAHHS; David Fassler, Vermont Psychiatric Association.

Guests/Public:

Tom Huebner, Jeff McKee and Susan Gerretson, RRMHC; Frank Pitts and Sara Wengert, Architecture +; Greg Miller, Retreat Healthcare; Cindy LaWare, AHS; Mike Kuhn, BGS; Jennifer Garson, BISHCA; Anne Donahue; Clifford Peterson, Kimbell & Storow, LLP; Maureen Mayo, VCIL; Bill McMains, DMH.

Staff:

Judy Rosenstreich and Norma Wasko, DMH.

Introduction

Michael Hartman welcomed everyone, acknowledging this to be the last Futures Advisory Committee meeting. He expects that its successor, the Advisory Council for Mental Health Services Transformation, established by the legislature this year (Act No. 65), will be formed in early fall and have a broader focus than the Futures project. Michael introduced the presenters: Rutland Regional Medical Center and Architecture+.

Rutland Regional Medical Center

CEO Tom Huebner briefly described his 32 years in health care, beginning with the Massachusetts Department of Health and from there working at a community hospital where he helped to create a psychiatric unit. Almost throughout his 17 years at RRMHC, Tom has served on the board of Rutland Mental Health Services. He characterized the hospital's interest in partnering with DMH on the Futures project as turning a significant corner in that the proposal reflects a strengthened commitment to enhance psychiatric inpatient services in Rutland. The hospital's proposal to renovate and reconfigure its

space, adding 6 beds for psychiatry, would essentially double our inpatient psychiatric capacity to 25, explained Tom.

Dr. Jeff McKee, the director of psychiatry services at RRMC, introduced the work he has done since assuming this position in December 2006. Jeff described changes underway, starting with a new Psychiatric Services Leadership Team. In addition to Jeff's role as director, the team includes a medical director, staff psychiatrist, director of psychiatric nursing services, manager of social work and utilization review, and a clinical leader. He recognizes the challenges inherent in a whole new leadership team yet also its potential for facilitating cultural change in the organization.

Jeff articulated some of the Rutland hospital's planned changes to its psychiatry services. They aim to build greater collaboration with consumers, advocates, and community representatives; Rutland Mental Health Services, through a staff sharing agreement; and Serenity House in Wallingford, becoming more welcoming of patients with substance abuse treatment needs.

Providing context to RRMC's proposed expansion of their inpatient psychiatric capacity, Jeff described the current unit design. There are two wings, one locked and one open. It is limited by virtue of square footage and layout to a functional capacity of 14 or fewer beds even though licensed to serve 19. The treatment area is small, rooms are shared.

The proposed renovation would provide 25 beds: a 6-bed general unit (open); 13-bed specialized unit (locked); and 6-bed intensive care unit (locked). More treatment area, outdoor space, and the ability to utilize the full, licensed capacity would be realized.

Discussion

Xenia asked if each patient would have their own room. Jeff clarified that the proposal requires a significant number of shared rooms. If we were to go with single occupancy rooms, it may not be possible to reach a capacity of 25, he added. Xenia responded that people like their own rooms as that is the only place to go where they have control. If RRMC wants to be patient-centered, single rooms are a good place to begin, she said.

Kitty asked about the average length of stay (LOS). Jeff advised 5.8 days this fiscal year. Also of concern is the number of people sent to the state hospital from RRMC and how many are discharged to the community, stated Kitty. Dr. Susan Gerretson, stating that she has been full time as medical director since April, offered that in her experience they have tried not to send people to VSH but rather to provide treatment on their own unit.

Linda asked what would happen to the medical rehabilitation unit adjacent to the existing psychiatric program. Tom Huebner explained that federal standards make it somewhat difficult to sustain a rehabilitation unit, citing the 75 Percent Rule.¹

¹ This rule requires a facility to show that it serves an inpatient population of whom at least 75 percent require intensive rehabilitation services for the treatment of one or more of 13 specified conditions in the most recent 12-month cost reporting period.

David offered his opinion on the issue of private rooms, stating it would be challenging to gain BISHCA's approval for a plan with mostly shared rooms. Frank Pitts clarified that national standards² require private rooms for general medicine but not yet for psychiatry. By 2010, the standard may go to private rooms as the trend appears to be clear, according to Frank. Modifying RRMC to all private rooms would be considerably costlier than the proposal now under consideration. David suggested it would be useful to have both options on the table---the currently proposed configuration with its associated costs and the alternative with all private rooms. Frank shared that Architecture + plans discussion with RRMC on capital costs.

On the issue of position retention, David stated that the Rutland community has been challenged, historically, to retain qualified psychiatric staff positions. Jeff expressed optimism given their success in building a new leadership team and hiring doctors aligned with their vision.

Concerning the relationship between RRMC and Rutland Mental Health Services, Tom stated that the two programs share patients every day and that the affiliation needs to continue. The two organizations have an interplay of interests, for example, Tom serves on Rutland Mental Health's search committee to replace former CEO, Mark Monson.

Linda focused on how and to what extent a recovery model of treatment fits into RRMC's proposal and vision. Jeff talked about the past, a time when the hospital might be apt to find another placement for some patients, making clear that they are doing things differently today. Linda expressed frustration with the Rutland community's limited progress in gaining an understanding of recovery as compared to the rest of the state. She is hopeful that we all are trying to bring this about for Rutland. We have not focused on recovery nor do we have a specific plan for recovery, Jeff stated. We are, however, very open to the conversation and want to engage in this process.

Following discussion, Michael noted that there may be more questions that Advisory Committee members wish to ask. He suggested that questions be sent to Beth. DMH will compile them and distribute responses from RRMC to the Advisory Committee.

PUBLIC COMMENT

Anne offered her opinion that due to past experiences with Rutland hospital's psychiatry program, there is a question of trust in their ability or commitment to fulfill a new vision. Jeff underscored the complete turnover of leadership of the psychiatry unit and the beginning of change taking place.

² American Institute of Architects

Architecture +

Frank Pitts provided an overview of his work on the Futures project including meetings with the Facilities Work Group of the Advisory Committee and focus groups with VSH staff, consumers and family members. He has advised the project on national standards and developing trends in the design of psychiatric inpatient programs. Psychiatric care is changing. Architecture is changing accordingly. What is being asked of buildings is different as a result of current and anticipated clinical approaches and opportunities. Research and changes in treatment are having the largest impact, from palliative care to active treatment. Accommodations for brain imaging is an important consideration. The environment, the milieu, to strive for is a recovery oriented, trauma informed, patient and family friendly treatment setting.

Frank illustrated how much has changed in the approach to clinical and conceptual design planning. Today, architectural planning needs to accommodate the recovery movement. New bedrooms are private bedrooms. Treatment settings provide a range of meaningful choices for patients. Emergence from private bedroom to group settings is built in to the treatment environment so patients can experience progressively more open environments.

In terms of unit size, Frank explained that 6-8 beds is the size that works best for patients in that it seems to reflect the scale at which unrelated adults can be more comfortable. From a clinical treatment team point of view, 12-16 patients provides enough people with similar needs to support program activities such as group treatment. From an administrative perspective, 24 beds is more cost effective. So the architectural design is best if it can be built to accommodate small residential clusters of 6-8, unit configurations of 12-16, all served by common administrative, nursing and treatment spaces for 24 people.

Frank presented these architectural concepts in some detail. He gave these and other examples.

- **House:** Inpatient Cluster and Nursing Support -- patient rooms, activity/recreation, exercise, dining room, kitchenette, quiet activity, visiting/consult room
- **Neighborhood:** Social/ Therapy Cluster and Clinical Team Cluster -- multi-purpose room, group therapy, exercise/fitness, clinical team cluster, clinical staff offices, unit mailboxes
- **Downtown:** library, gift shop, chapel, classrooms, courtroom, pharmacy, medical clinic

Safety and security are important, continued Frank, but not a jail-like setting where you can see everything. Innovations in mental health safety and security emphasize passive security and visibility; it is not primarily about hardware and electronics.

- Staff can not provide effective treatment in an environment that is not safe and secure.
- Patients can not heal in an environment that is not safe and secure.

Frank summarized current best practices to keep patients safe. Fixtures and installations are designed for safety, such as door bumpers, cabinet hardware, lavatories, faucets, shower actuators, plumbing traps and piping, grab bars, furniture and toilet accessories.

Discussion of Architectural Presentation

David asked whether new inpatient psychiatric facilities should ideally be on one floor. It is important to have the “house” and “neighborhood” areas on one floor, stated Frank; “downtown” space should be as close as possible. In larger hospitals, keeping downtown on the same floor may create more distance and obstruction than traveling a floor. What about the issue of staff space, asked David? For the size and numbers of staff Vermont is considering, Frank agreed that it is preferable for staff to be on the same floor as patients.

Frank described a model with three 7-bed clusters on a single floor, sharing a downtown. To maximize space for the clinical environment, locate other services on a separate floor.

Xenia asked about telephone and visiting access, citing Dartmouth-Hitchcock Medical Center (DHMC) facilities that provide each patient with a phone and private line. Frank explained that the building design would equip every bedroom with Cat 5e³ wire, leaving it up to operations to decide whether to plug in a phone. A diversity of visiting options would include a place in each 8-bed cluster, near the nurses station, and in downtown.

Linda commented that the place for architectural space looks good, so much so that she questioned whether patients would have an incentive to leave the hospital. Frank said that you need to make it rich enough to test patients’ competencies while still there. Frank shared that in Rochester, New York’s new inpatient facility, the average length of stay went down, and that the tendency has been a reduced LOS in new hospital buildings.

PUBLIC COMMENT

Anne explored with Frank the clinical benefit of the “downtown” with its range of amenities (library, bank, canteen, recreation, chapel, etc.) as compared to a rapid reintegration to the community.

Discussion Resumes

Paul Dupre asked how the proposed hospital design connects with the community. Are there ways to release people during their hospital stay to, say, go see their physician? Beth offered that that was more a matter of clinical practice than architectural design.

³ Category 5 enhanced wiring is high-speed data transmission wire for telephone and computers.

Michael Hartman raised some issues that have emerged as we have done the analysis of inpatient psychiatric needs. The Advisory Committee recommendation of 50 beds has elicited some feedback from our legislative consultants, suggesting perhaps fewer beds. How do we address the forensic population? Consideration is being given to longer term patients who may be involved in a legal process, although they would not meet the acuity standards for inpatient treatment.

Kitty observed that significant numbers of people coming into the mental health system have been incarcerated, detained, or under the supervision of Department of Corrections.

Linda added that many people from the court-ordered side are finding the care they need in the community. A problem they are experiencing in Rutland is that the regular doctors will no longer prescribe their medications. What are they supposed to do? This may lead to VSH admission or to Corrections.

Nick underscored these problems---medical, legal entanglements, safety issues---that make it difficult to fulfill individuals' needs in the community yet we know that acute inpatient beds are the most expensive care.

Xenia offered support for peer crisis units where people who do not find drug treatment useful can get help. She stated that research shows that peer support programs are more efficacious than drug treatment. If Vermont had a place to go such as Stepping Stones in New Hampshire, this could potentially siphon off people who otherwise may go to VSH. It would make the whole mental health system closer to what the legislature envisioned in Act 114, a system without coercion, stated Xenia.

Paul raised another concern: As VSH gets smaller, where will people with developmental disabilities for whom housing options are limited, and who present danger to themselves or others go? It has become harder to find staff, harder to find people who will rent to us. The levels of danger are fairly extreme. This part is not addressed as well in Futures. We may need a safe place for them and staff. The potential impact on the community is high.

Michael Hartman commented on the historic role of the state hospital filling not only a clinical need but also a social/community need. As we continue planning for successor programs to VSH, this will have to be addressed.

Linda commented that each time the State has downsized VSH, there has been an impetus to increase resources in the community. This seems to decline, services are less robust, and people become vulnerable of being institutionalized.

PUBLIC COMMENT

Anne informed the group that the Legislative Council has available a CD of the last meeting of the Corrections Oversight Committee. The next meeting is September 11th.

Michael Hartman thanked the members of the Futures Advisory Committee for their sustained work on the Futures project and their contributions to the planning process.

The meeting adjourned at 4:15 p.m.

SUBMITTED BY: Judy Rosenstreich
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